SERFF Tracking Number:	*AMFD-127983181*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5039*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Policy Change Application*		
Project Name/Number:	*5039/5039*		

Filing at a Glance

Company: Sagicor Life Insurance Company

Product Name: Policy Change Application	SERFF Tr Num: AMFD-127983181	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L08.000 Life - Other	Co Tr Num: 5039	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Francine Cardon	Disposition Date: 01/17/2012
	Date Submitted: 01/12/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 5039	Status of Filing in Domicile: Authorized
Project Number: 5039	Date Approved in Domicile: 01/03/2012
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/17/2012
	State Status Changed: 01/17/2012
Deemer Date:	Created By: Francine Cardon
Submitted By: Francine Cardon	Corresponding Filing Tracking Number:

Filing Description:

RE: Sagicor Life Insurance Company
NAIC No.: 60445; FEIN: 74-1915841
Form Nos.: 5039 Policy Change Application

The above referenced form is being submitted for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. These documents are final printed versions. The Application will be used by the policyowner to make changes to their in-force term life; whole life, and universal life policies.

SERFF Tracking Number:	*AMFD-127983181*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5039*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Policy Change Application*		
Project Name/Number:	*5039/5039*		

5039 will be in paper and electronic format. Electronic format means the application may be in an electronic format for policyowner or producer's use instead of paper. If the electronic format is utilized, all required signatures will be verified by assigning a code to the proposed insured/policyowner. If the agent is present, the agent must verify that the person signing is whom they claim to be, by asking for a government issued identification form, such as a passport or a driver's license. If the agent is not present, the signer must insert the code prior to viewing and signing the application.

Please note that we may change the appearance and pagination but not the text of these forms to comply with future changes in print systems. No font will be less than 10 point size. The color and/or weight of the paper may change. No changes to the text other than corrections of typographical errors will be made to the form without re-filing them with you.

Should you have any questions, please contact me toll-free at 480.425.5100 ext. 5652, or via electronic mail at francine_cardon@sagicor.com.

Thank you for your consideration.

Sincerely,

Company and Contact

Filing Contact Information

Francine Cardon, Compliance Analyst
4343 N. Scottsdale Road
Suite 300
Scottsdale, AZ 85251

Francine_Cardon@sagicor.com
480-425-5100 [Phone]
480-425-5150 [FAX]

Filing Company Information

Sagicor Life Insurance Company
4343 N. Scottsdale Road
Suite 300
Scottsdale, AZ 85251
(800) 531-5067 ext. 5653[Phone]

CoCode: 60445
Group Code: 3766
Group Name:
FEIN Number: 74-1915841

State of Domicile: Texas
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00

SERFF Tracking Number:	*AMFD-127983181*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5039*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Policy Change Application*		
Project Name/Number:	*5039/5039*		

Retaliatory? Yes

Fee Explanation: Domicile state filing fee is $100 per filing.

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sagicor Life Insurance Company	$100.00	01/12/2012	55260928

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	$0.00	

SERFF Tracking Number:	*AMFD-127983181*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5039*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Policy Change Application*		
Project Name/Number:	*5039/5039*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/17/2012	01/17/2012

SERFF Tracking Number:	*AMFD-127983181*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5039*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Policy Change Application*		
Project Name/Number:	*5039/5039*		

Disposition

Disposition Date: 01/17/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFD-127983181*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5039*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Policy Change Application*		
Project Name/Number:	*5039/5039*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Policy Change Application		Yes

SERFF Tracking Number:	*AMFD-127983181*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5039*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Policy Change Application*		
Project Name/Number:	*5039/5039*		

Form Schedule

Lead Form Number: 5039

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	5039	Application/ Enrollment Form	Policy Change Application	Initial		50.000	5039 Chg App file copy 1.11.12.pdf

Sagicor
LIFE INSURANCE COMPANY

Policy Change Application

Policy Number: _____

SECTION 1 – Requested Change *(Please check all that apply)*

☐ Specified Amount Increase ☐ Reinstatement ☐ Rate Reduction ☐ Additional Riders
☐ Death Benefit Option Change ☐ Nicotine/Tobacco to Non-Nicotine/Non-Tobacco

SECTION 2 – Proposed Insured Information

Name: _____ Sex: ☐ Male ☐ Female
(First) (MI) (Last)

Street Address: _____ Social Security Number: _____
City State ZIP Code

Telephone No. : Home _____ Work _____ Other: _____

Height: _____ Weight: _____ Date of Birth: _____ Place of Birth: _____

Is the Proposed Insured a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 3 – Proposed Owner Information *(Complete if different from the Proposed Insured)*

☐ **Check if Proposed Owner is not an Individual** *(If this is a Trust, please provide a copy of the Title & Signature page)*

Name: _____ Date of Birth/Trust Date: _____
(First) (MI) (Last)

Street Address: _____ SSN/Tax ID #: _____
City State ZIP Code

Telephone No.: Home _____ Work _____ Other: _____

Is the Owner a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 4 – Beneficiary Information

(If there are Additional Beneficiaries, attach information on a separate sheet of paper)

☐ **Check if the Beneficiary is not an Individual**

Primary Beneficiary Name: _____ Relationship: _____

Street Address: _____
City State ZIP Code

Social Security Number/Tax ID: _____ Date of Birth/Trust Date: _____

Is the Primary Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 4 – Beneficiary Information (*continued*)

(If there are Additional Contingent Beneficiaries, attach information on a separate sheet of paper)

☐ **Check if the Contingent Beneficiary is not an Individual**

Contingent Beneficiary Name: _____ Relationship: _____

Street Address: _____

City *State* *ZIP Code*

Social Security Number/Tax ID: _____ Date of Birth/Trust Date: _____

Is the Primary Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 5 – Coverage Selection

a. Life Amount/Plan of Insurance

Current Amount in Force $ _____ Total Desired Amount $ _____

Plan _____ Amount of Cash Submitted with Application $ _____

b. Additional Benefits

☐ Waiver of Premium ☐ Child Rider ☐ Accidental Death Benefit

☐ Other _____

c. Universal Life Products

Death Benefit Option Change

Current Option: ☐ Option A ☐ Option B

Desired Option: ☐ Option A ☐ Option B

Planned Periodic Payment Change

Current Amount/Mode $ _____

☐ Monthly EFT ☐ Quarterly ☐ Semi-Annual ☐ Annual

Desired Amount/Mode $ _____

☐ Monthly EFT ☐ Quarterly ☐ Semi-Annual ☐ Annual

SECTION 6 – In Force/Replacement Information *(If YES to any question, list information below)*

1. Will any life insurance or annuity in this or any other company be replaced or changed as a result of this application? *(If **YES**, please list the policy or contract below & complete a Replacement Form.)* ☐ Yes ☐ No
2. Does the Proposed Insured:
   a) Have any other life insurance or annuity in force? ☐ Yes ☐ No
   b) Have any application (including reinstatement) for life insurance or annuity now pending? ☐ Yes ☐ No
3. Has the Proposed Insured applied for any life insurance or annuity in the last ninety (90) days? ☐ Yes ☐ No

   *(If **YES**, please list the policy or contract below.)*

Name of Proposed Insured	Company	Policy #	Amount	Issue Date	Plan Type

SECTION 7 – Health and Medical Questions, Personal History and Lifestyle Related Questions

1. Have you ever flown or intend to fly in the next two years as a pilot or crew member of any aircraft other than a commercial airline? (*If you answered **YES**, please complete an Aviation Questionnaire.)* ☐ Yes ☐ No
2. In the last **24** months, have you participated in: sky diving, scuba or skin diving, vehicle or motorcycle racing, rodeo activities, hang gliding, bungee jumping, or ballooning? (*If you answered YES, please complete an Avocation Questionnaire.)* ☐ Yes ☐ No
3. Have you ever had an application for insurance or reinstatement of insurance declined, postponed, rated or modified? ☐ Yes ☐ No
4. Are you actively at work on a full-time basis as of this date, and have you been actively at work for the past 90 days? ☐ Yes ☐ No
5. Have you ever been diagnosed as having or been treated by a member of the medical profession for:
   a) heart disease or disorder, high blood pressure, stroke, cancer, diabetes, or kidney disease? ☐ Yes ☐ No
   b) ulcers, colitis, hepatitis, or any other disease or disorder of the liver, gallbladder, pancreas, stomach, rectum, or intestines? ☐ Yes ☐ No
   c) asthma, emphysema, tuberculosis, or any other disease or disorder of the lungs or respiratory system, sleep apnea, or do you use oxygen? ☐ Yes ☐ No
6. Have you tested positive for Human Immunodeficiency Virus (HIV); or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS); or the AIDS Related Complex (ARC)? ☐ Yes ☐ No
7. Have you used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or gum in the last ☐ 2 ☐ 3 ☐ 5 years? ☐ Yes ☐ No
8. In the last **10 years**, have you received advice, treatment, by a member of the medical profession or been convicted for the use of alcohol? In the last **10 years**, have you used, received advice for, been treated by a member of the medical profession for, or been convicted of the use or possession of any narcotic, stimulant, sedative, or hallucinogenic drug? ☐ Yes ☐ No
9. Have you ever been diagnosed as having or treated by a member of the medical profession for memory loss, dementia or Alzheimer's disease? ☐ Yes ☐ No
10. Do you require assistance to perform any 2 of 6 Activities of Daily Living (ADL's)? (ADL's are: eating, toileting, transferring, bathing, dressing, and continence.) Are you currently in a nursing home? ☐ Yes ☐ No
11. **Have you seen any doctor, or had any illness, medical treatment, exam or surgery, or taken any medication not mentioned above in the last five years?** ☐ Yes ☐ No

Details to "Yes" answers: _____

SECTION 8 – Authorization and Acknowledgement

For your protection, the law requires that a warning against insurance fraud appear on this application. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I understand that I am applying for life insurance coverage issued by Sagicor Life Insurance Company ("Sagicor"). I understand and consent that this application, and information obtained pursuant to this authorization may be used by Sagicor to evaluate my eligibility for life insurance.

I authorize the release to Sagicor of all information requested about me or any of my minor children proposed to be insured. This information may be released to Sagicor's authorized representatives. Authorized representatives include any consumer reporting agency acting on their behalf. Each of the following may be a source of information: the Medical Information Bureau, Inc. ("MIB"); my employer; physician, medical practitioner, hospital, clinic, or medically related facility; insurance or reinsuring company; consumer reporting agency; any other organization or insurance support organization; and a Pharmacy Benefit Manager.

Information means facts about me or any of my minor children that are proposed to be insured. Those facts include, but are not limited to; information about mental or physical health; other insurance coverage; use of drugs or alcohol; motor vehicle records; avocations; employment; prescription drug records; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits.

I understand and agree that Sagicor may disclose all or some of my information to its insurance administrators, its reinsurance companies, the producer who solicited my application and his or her principals, the MIB, and other persons or organizations performing business or legal services in connection with my application.

This authorization shall be valid for 30 months. I understand that I or my authorized representative may receive a copy of the authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by sending written notice to Sagicor's home office. I understand that my right to revoke this authorization is limited to the extent that Sagicor has not already taken action in reliance on the authorization.

To the best of my knowledge and belief, the statements and answers given on this form are true, complete, and correctly recorded. I understand that the requested change does not go into effect and no liability exists for Sagicor until Sagicor notifies the owner in writing and the first full premium is paid if requesting a reinstatement, and there has been no change in the health of the Proposed Insured(s) that would change any of the answers in this application. I understand and agree that no producer may accept risks or pass upon insurability, make or modify contracts, or waive any of Sagicor's rights or requirements.

To help the government fight the funding for terrorism and money laundering activities, federal law requires all financial institutions obtain, verify, and record information that identifies each person who opens an account. What this means for you: when you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We will also ask to see your driver's license or other government issued photo identification. If you wish to have more detailed explanation of our information practices, please write to: Sagicor Life Insurance Company; Attention: Client Services Department; PO Box 52121; Phoenix, AZ 85072-2121.

Under the penalties of perjury, by my signature on this application, I certify that: (1) the Social Security number shown on this application is my correct taxpayer identification number and, (2) I am not subject to back-up withholding either because I have not been notified by the IRS that I am subject to back-up withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to back-up withholding.

Signed: _____ Date Signed: _____

City State

_____
Proposed Insured Signature
(If a minor, signature of parent or guardian)

_____
Proposed Owner Signature
(If other than the Proposed Insured or Trustee)

_____
Additional Signature if necessary
(Assignee, Spouse, etc.)

_____
Proposed Trustee Signature *(if applicable)*

_____
Writing Producer's Name *(Please Print)*

_____
Writing Producer's Number

_____
Writing Producer's Signature

_____
Countersigned
(Licensed resident producer if state required)

SECTION 9 – This section should be completed by the Producer.
For questions about this application or requirements, contact our Underwriting Department.

Producer Name (Please Print)	Producer ID Number	% Split

Each licensed Producer will share equally unless otherwise indicated.

1. Have you delivered the consumer protection notices to the Proposed Owner(s) and Proposed Insured(s)? ☐ Yes ☐ No
2. Did you personally meet with the Proposed Owner(s) and Proposed Insured(s), obtain their Social Security Number(s) and view for each a Government issued photo ID? *(If **YES**, specify the type of ID and ID number. If **NO**, please explain why.)* _____ ☐ Yes ☐ No
3. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Owner? ☐ Yes ☐ No
4. Does the Proposed Insured(s) have any other life insurance or annuities currently in force or pending reinstatement? ☐ Yes ☐ No
5. Will any annuity or life insurance presently in force be replaced or changed by this policy that is being applied for? *(If **YES**, and if required by state regulation, any Replacement Comparison, Notice, or Statement must accompany this application.)* ☐ Yes ☐ No
6. Is this a 1035 Exchange? *(If **YES**, attach all required forms.)* ☐ Internal ☐ External ☐ Yes ☐ No
7. Is this a premium finance case? ☐ Yes ☐ No
8. How long have you known the Proposed Owner(s)? _____ Proposed Insured(s)? _____
9. Are you related to the Proposed Owner(s)? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
   If **YES**, how are you related? _____
10. Are the Proposed Owner(s) U.S. Citizen(s)? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
    If **NO**, how long have they been in the U.S.? _____ What type of Visa? _____
11. Does the Proposed Owner(s) understand and speak English? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
    If **NO**, please explain: _____
12. Was any other person present to answer questions? ☐ Yes ☐ No
    If **YES**, who was present and why? _____
13. What is the purpose of this insurance purchase? _____
14. Do you know of anything not disclosed in this application that may affect the risk of this life insurance purchase?
    ☐ Yes ☐ No If **YES**, please explain: _____
15. Sagicor is responsible for ordering all medical requirements. If the requirements are ordered by the producer, please indicate the requirements ordered and the company. Paramed Company: _____
    Date Ordered: _____ ☐ Blood Profile/HOS ☐ MD Exam ☐ Treadmill EKG ☐ EKG ☐ Paramedical Exam
16. Remarks: _____

Producer's Certification

I certify that I saw and know the Proposed Owner(s) and Proposed Insured(s) to be the person(s) described in this application, and have reviewed the appropriate documentation, and have truly and accurately recorded the information supplied by the Proposed Owner(s) and Proposed Insured(s), that I know of no condition affecting the insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

Signed (Writing Producer): _____ Date Signed: _____

Phone Number: _____ Fax Number: _____ E-mail Address: _____

Sagicor

LIFE INSURANCE COMPANY

Disclosure Notice to Proposed Insured

Leave with the Proposed Insured

Investigative Consumer Report Notice

You are our most important source of information, but personal information may also be collected from other sources. Such information may, in certain circumstances, be disclosed to third parties without your authorization.

An investigative consumer report may be prepared in which information is obtained from public records and through personal interviews with: your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed as part of the report. Upon written request to Sagicor, further information on the nature and scope of the report will be provided.

Information Practices

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other persons or organizations without your written authorization, except to the extent necessary to conduct our business, as permitted by law, or as required by law. You have the right to be told about and obtain access to certain items or personal information in our files. You also have the right to request correction of information you believe to be inaccurate. If you would like to receive a more detailed explanation of our information practices, please write to:

Sagicor Life Insurance Company
Attention: Compliance Department
P.O. Box 52121
Phoenix, AZ 85072-2121

Medical Information Bureau (MIB) Notice

Information regarding your insurability will be treated as confidential. Sagicor or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB). The MIB is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life insurance or health insurance coverage, or a claim for benefit is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. MIB's toll free number is 866-692-6901 or TTY 866-346-3642. Website www.mib.com.

Sagicor Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

SERFF Tracking Number:	*AMFD-127983181*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5039*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Policy Change Application*		
Project Name/Number:	*5039/5039*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
5039 Read Cert.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Please refer to the application placed under the Form Schedule.
Comments:

READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms achieved a Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

Form #	Title	Flesch Score
5039	Individual Life Insurance Conversion Application	50.0

Sagicor Life Insurance Company

Name: James Golembiewski
Title: VP Compliance & Associate General Counsel

January 11, 2011
Date